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FEBRUARY 1979

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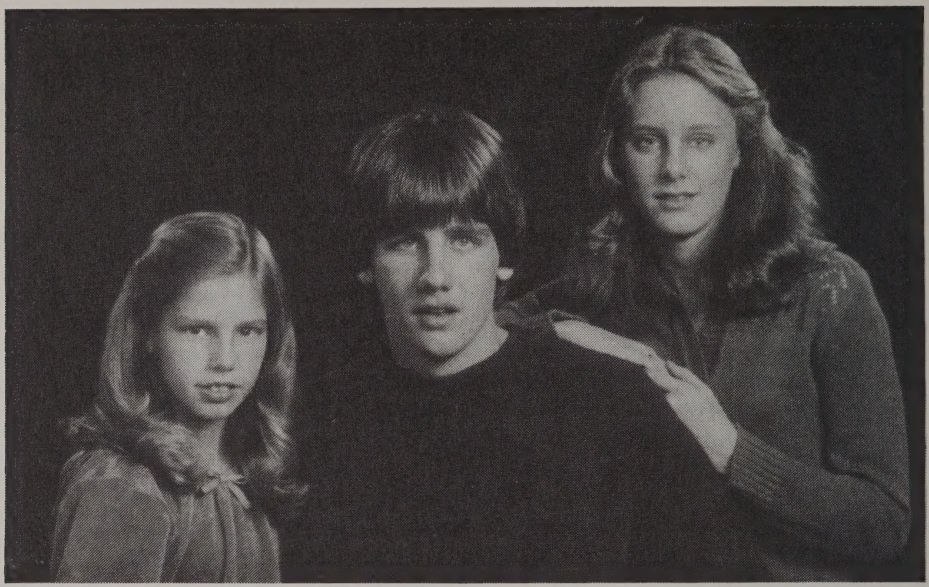

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THE HAMPDEN HIPPOCRAT IS PUBLISHED MONTHLY EXCEPT FOR JULY AND AUGUST.
THE OPINIONS EXPRESSED IN THIS BULLETIN ARE THOSE OF THE WRITERS AND DO NOT REFLECT THE OFFICIAL VIEWPOINT OF THE HAMPDEN DISTRICT MEDICAL SOCIETY UNLESS SO STATED.
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PRESIDENT'S PAGE

"FEES"

The doctors say they are too low - the public says too high. Some say there should be no fee at all - that physicians should pay the patients for what they do to them. George Bernard Shaw thought that it was ridiculous to pay the highest fee for the most extensive and destructive medical or surgical procedure.

I am afraid that I do not have the answer to the fee dilemma, but a few comments might be in order.

Physicians are certainly entitled to fair compensation for their efforts. Almost to a man or woman, they have worked hard and long to obtain their skill. The expenditure of time, toil and money which has gone into their training is immense. The competition to obtain the coveted MD degree is intense. By and large, the average physician is a highly intelligent, over achieving, workaholic - with a magnificent education and years of post graduate study - a combination which would well nigh assure financial success in any field of endeavor.

The physician's capacity to earn starts late in life - at a time when some government workers are beginning to have their first ruminations about an early retirement with a rather generous pension. The medical practitioner must "make it big" in a relatively few years and provide for his retirement more or less on his own.

To some extent, doctors have probably succumbed to the American concept which tends to equate success with the accumulation of riches. The big sport's star is rewarded with a million dollar contract - the movie idol receives millions for what appear to be rather meagre efforts. The malpractice situation hasn't helped much. If a lawyer can convince a jury that a slip of the knife is worth a couple of million, can the physician be blamed if he feels a steady hand with a knife is worth a couple of thousand.

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Perhaps fee for service should go out the window. But despite the fact that the vast majority of physician's chief concern is for the welfare of their patients, there are lingering fears, Edward Bellamy to the contrary, notwithstanding, that when financial incentives decrease, productivity does as well.

When the public thinks of the doctor's fee, they should be aware of the tremendous expense of training, study, self discipline and dedication which is involved in every physician encounter. They should be aware of the great benefits which the skillful doctor can bring - illnesses which just a few years ago were disabling or fatal are now readily controlled or corrected by everyday medical or surgical manipulations. Our skill is so great, that it is taken for granted and therapies which are truly medical miracles are expected as much as the air we breathe.

Physicians, for their part, should remember that their mission in life is to prevent illness and help the sick. The accumulation of great wealth is not all that good. Practitioners of the healing art should not burden themselves and their families with an overabundance of riches. Many of our patients are poor - we do not want to wax fat on their property. □

JOHN J. FLAHIVE, M.D.

WHAT CAN YOU DO FOR YOUR MEDICAL SOCIETY

To those of you who would like to become more active in our medical society, I suggest you make your interest known to the Nominating Committee, for next years appointments.

Nominations for President, Councilors and Executive Committee postions are annually open.

You need not think that you need to be an "all timer" like some of us have become involved.

Members of the Nominating Committee to contact are Terry Ryan, Lorne Smith and myself □

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EXECUTIVE COMMITTEE MEETING

January 16, 1979

The Executive Committee of the Hampden District Medical Society met on Tuesday, January 16, 1979 in the Conference Room.

Present were Drs. Flahive, Walthall, Remsberg, Magill, Fitzpatrick, Sachsse, Navazio, Stoddard and Mrs. Purdy. Absent were Drs. Bloom, Verrilli, Zadworny, Dasco and Corsaro.

The minutes of the December meeting had been mailed out to the committee and were accepted as written.

Dr. Stoler was present at Dr. Flahive's invitation to discuss the Western Mass. Health Planning Council and particularly the Board Development Committee of which he is a member. Dr. Stoler indicated that he does not have sufficient lead time on information which is to be on the agenda of the meetings. The committee stated that Dr. Stoler is the representative from the Hampden District Medical Society and should feel free to make decisions as he sees befitting. A summary of the state plan was obtained and a copy will be sent to Dr. Stoler.

OLD BUSINESS

The subject of membership for the Countway Library was brought to the attention of the Hampden District Medical office. Securing membership is quite involved and after discussion it was decided to write the Massachusetts Medical Society and suggest that membership cards be given at the time the physicians pay their dues.

The suggestion of a visit from Dr. Perry Culver to Springfield to talk with the Executive Committees of both the Academy of Medicine and the Hampden District Medical Society was accepted by the Academy and a date will be made for Dr. Culver's visitation.

Dr. Verrilli's resolution made at the November 21 membership meeting had been revised and was read for approval.

NEW BUSINESS

Three different awards are offered by the American Medical Association in different categories and will be considered by the Board of Trustees in March of 1979 for presentation at the Annual Meeting.

Mrs. Purdy asked if the Hampden District Medical Society would purchase the American Medical Association Directory which is used constantly in the office. The committee gave approval of the expenditure.

The committee approved Dr. Flahive's appointment of Dr. Paul T. Moore as Auditing Chairman to replace Dr. Kennedy.

Mrs. Purdy gave the office report. The telephone listing has been completed with the yellow page listing for the Springfield telephone book. Public Hearings for the state HSA will be held on Tuesday, January 23, 1979 at STCC.

The meeting was adjourned at 9:05 P.M. □

PHILIP B. STODDARD, M.D.
Secretary

CONTINUING EDUCATION

The Board of Registration and Discipline in Medicine will from time to time supply the H.D.M.S. office with pertinent information pertaining to keeping the physicians informed of its current activities, changes in Rules and Regulations Governing the Practice of Medicine and the types of disciplinary decisions made and the reasons for them.

Therefore, the Hampden Hippocrat, will cooperate with the Board and print this information as it is supplied to the office of the medical society. This first printing deals with Continuing Education. Other facets of information will follow in future issues.

Continuing Medical Education Requirements for Re-registration in 1980

The Board's rules and regulations originally required 40 hours of Category 1 credits and 60 hours of Category 2 to 6 as established by AMA and the AOA. The rules have most recently been amended to clarify the requirement and read as follows:

A minimum of 40 hours of Category 1 credits (maximum of 100 hours if one wants to take only Category 1 credits)
A maximum of 60 hours in Category 2-6 with the following limits for each category:*

30 hours	Category 2
30 hours	Category 3
27 hours	Category 4
30 hours	Category 5
30 hours	Category 6

*Note that the Board's requirements are based on a two-year cycle. The Physician Recognition Award and the Massachusetts Medical Society's requirements are based on a three-year cycle.

The Board previously amended its rules and regulations to allow a physician to fulfill the CME requirements with 100 hours of Category 3 and 4. The amendment has been rescinded and anyone who believes he/she qualifies for a special program should petition the Board for approval of a special program under Section V.3.h. of its rules.

Documentation and Verification of Continuing Medical Education Activities

The Board's policy on verification of continuing medical education credits is as follows:

In the re-registration packet, an IBM card for reporting CME activities will be included. Physicians will be asked to state how they have fulfilled their requirements and to sign the following statement:

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The Board will verify the information given on these cards by tuilizing existing rosters and print-outs such as: AMA list of recipients of Physicians Recognition Award, active members of the Massachusetts Medical Society, list of physicians who have become either Board certified or re-certified in the preceeding three years, etc., list of interns and residents.

The Board **will randomly ask some physicians**, whose continuing medical education credits cannot be verified with the data in the office, to forward evidence of the credits listed on their re-registration forms. All physicians are urged to keep adequate records of their CME activities. The Board will expect adequate documentation of Category 1 credits and will use its discretion in evaluating whatever evidence is available for accredited categories (2 to 6) of CME activities. Audits will be conducted in the two years immediately following re-registration. All documents related to continuing medical education for 1978-1980 may be destroyed at re-registration time in 1982.

Please do not mail any evidence of CME credits unless requested to do so by the Board.

Waivers of Continuing Medical Education Requirements

The Board may waive CME requirements because of prolonged illness, or because of inaccessibility or unavailability of continuing medical education activites. The Board has so far received fewer than 50 such requests. Any physician who intends to petition the Board for a waiver of the CME requirements should do so as soon as possible. All waivers must be approved by the entire Board.

Inactive Status

A physician who wishes to keep his license in Massachusetts, but who does not intend to practice in Massachusetts, and who does not

want to fulfill the Board's CME requirements may request he/she be granted inactive status. The cost for re-registration is $50.00.

A physician who does not wish to practice medicine, fulfill h is/her CME requirement, and also does not want to pay the re-registration fee of $50.00 may allow his license to be revoked automatically for failure of complying with re-registration requirements mandated by Chapter 112, Section 2. Any license so revoked may be re-instated upon completion of the re-registration requirements.

CME Requirements for Physicians who Become Licensed or Re-register in the Course of a Calendar Year

Physicians who become licensed for the first time in the course of a calendar year are not expected to fulfill any CME requirements for that year. **For example:** John Doe obtains a license in March of 1978. He is not expected to complete any CME courses in 1978, but is expected to complete half of the Board's requirements in 1979.

The same policy applies to physicians who request inactive status and later petition the Board to become active, and those who have allowed automatic revocation of their license, and later apply for re-instatement.

Post-Graduate Medical Education

The Board considers enrollment in an approved residency program leading to certification by a specialty board, as the equivalent of 50 hours of Category 1 credits per year. Several physicians currently enrolled in such programs have already requested a statement from the Board stating that they have fulfilled their requirements. **Please note that enrollment should be in the immediately preceeding three years. Example:** John Doe, M.D. was a pediatric resident up to June, 1977. He, therefore, is not expected to fulfill any other requirements for re-registration in 1980, and will have to fulfill 100 hours of CME activites for re-registration in 1982.

We hope that the information in this newsletter has been helpful. If you have any questions, please do not hesitate to contact us at (617) 727-3086. □

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OF SINS AND VIRTUES

To accept and sustain the old sentence according to which "everything new is not good and everything which is good is not new" is more and more difficult in a climate like our present one. We are indeed witnessing rapid though at times insidious processes of "new things", each affecting us directly. We obtain very little when we only talk back to those planning new health reforms, hospital re-organizations, full-time activity of physicians, and how frequentyly are these speakers motivated by other kind of interests rather than patient's care. To paraphrase Shakespeare, "Words without facts never reach the sky".

What we need instead is to act with prudence and perseverance. Prudence, in our criticism of extreme theses, theses of those who would like to obtain everything immediately (national health programs, employment of physicians on a full-time basis, etc.) and perseverance in a progressive discourse which is to be carrried on with decisiveness and without forfeit.

Physicians are expected to avoid, at all cost, false progress or infantile planning. Physicians should also avoid to assume positions which, if not offering any political outlet, would automatically lead to a strengthening of the opposition.

Our strategy should be one of initiative, movement and at times, adaptation ready nevertheless to push back any demagogic theory.

Our weapons? The constant display of facts with their practical and economical aspects and their past and present effect occurring here and in other countries.

When Senator E. Kennedy displayed his witnesses at the recent public hearings in Denver, in Chicago and in California, we heard harrowing stories of personal medical troubles followed by financial ruin.

Our reply should, in proper terms, demonstrate that American medicine has reached a level and a caliber second to none, that the great majority of the American population can indeed utilize this high level of medicine, that from all over the world students and scholars come to our centers to learn our achievements and that about 80% of the medical progress in the world stems from our medical centers, from our hospitals, in brief, from our systems.

Still we should all be for new advances in health programming and this should not be difficult as we have all been trained to update and to look at the future.

The approach that our Society suggests involves nevertheless, the taking of small steps, cautiously objecting to in dismay, who are seeking quick solutions.

Health reform is a problem of such importance and magnitude that it is fundamental to be right rather than be quick. □

FRANCO NAVAZIO, M.D.
President-Elect

LET'S AVOID THE FACTORS THAT HAVE DAMAGED LABOR'S POLITICAL CLOUT

Our AMA federation must shun the internal damage that has made organized labor much less effective in Washington, D.C., than the publicity accorded its leaders might suggest.

"Big labor isn't very big anymore," liberal syndicated columnist Nicholas von Hoffman wrote in the December issue of **Harper's**, adding, "the labor lobby has come down with pernicious anemia."

He further said:

"Without a kick in the pants of the kind unions can no longer deliver, labor must suffer increasing rejection from the national government. The last session of Congress saw organized labor lose almost everything it wanted, in particular the labor-law reform bill..." That bill would have eased the unions' organizing efforts.

As the primary reason for the loss of clout, von Hoffman cites the falloff in union membership to only about 20 per cent of the labor force. "Since 1974, unions have lost more than half a million members, whiule in the same period the economy added 6 million new jobs."

The lack of unity in the union movement could well be an additional reason, we believe. For example, the only three unions with more than a million members (according to the 1978 **World Almanac**]-- the Teamsters, United Auto Workers, and National Education Association-- are unaffiliated with the AFL-Cio.

In contrast with organized labor, the AMA has been effective in Congress and has improved its relations with the White House. To remain effective, however, our federation must grow in its portion of the total number of physicians and in unified membership.

In the 1977-78 Congress, our federation was instrumental in the demise of such offensive bills as:

* A bill to extend Federal Trade Commission jurisdiction to non-profit organizations, which would include the AMA, its component societies, and medical-specialty societies. Along with eliminating Congressional sanction of the FTC's current anti-trust action against physician solicitation of patients, the bill's death is likely to help us if the FTC administrative judge's adverse ruling on the issue has to be carried as far as the federal courts.

* A Health Planning Act amendment that would have extended certificate-of-need provisions to purchase of new equipment by physicians' offices.

* Mandatory cost containment, as contrasted with the Voluntary Effort spearheaded by the AMA, the American Hospital Association, and the Federation of American Hospitals, with splendid support from their state bodies.

* The proposed Clinical Laboratory Improvement Act, which would have set national standards for the training of lab technicians and harassed lab procedures in many physicians' offices.

* The drug regulation reform bill, which would have further muddled the development, distribution, and use of beneficial drugs.

Let's sustain our impact. And let's all work for the membership growth and unity that are needed to sustain it. □

THE A.M.A. IS CLOSER TO YOU THAN YOU MIGHT SUPPOSE

An ancient Greek thinker, Diogenes Laertius, wrote, "Mountains when far away appear misty...but when near at hand they are rugged."

Increased membership in the American Medical Association (up 8,000 in a year's time) reflects the extent to which physicians perceive the ruggedness.

They clearly see the AMA's strength against such dangers as mandatory cost ceilings, over-regulation of health planning, and Federal Trade Commission actions anent physician advertising and medical-school accreditation. They see the AMA's strength in upholding professional standards, serving the public and the profession, and taking voluntary socio-economic initiatives.

But to many non-members, the AMA indeed appears distant and misty. And, that sense of remoteness does not apply only to the national AMA. Doctors in their busy offices and hospitals may feel it toward their state and county societies.

AMA membership at the end of 1978 totaled 210,000, up from 202,000 the previous year. There was a gain from no less than 41 of the states and territories.

Of the 181,000 dues-paying memberships at last year's close, 149,000 were channeled from the state associations and 32,000 were direct.

There are estimates, however, that the total rosters of the state associations exceed that of the AMA by 50,000. Yet the AMA has been greatly expanding and intensifying its help to the states. For example, it has established a Department of Negotiations, malpractice reinsurance company (AMACO), state health legislation unit (which, among other things, drafts model bills), and Department of Federation Communications in recent years.

If more state association members belonged to the national AMA, the latter's $250 regular annual dues could be reduced substantially... to $200 or less.

The AMA House of Delegates last June slashed dues in half for physicians in their crucial first year of practice. Their membership affords such benefits as computerized placement service, practice-management workshops and guidance, legal counsel, and insurance (medical, life, disability, and so forth), as well as a role in staving off federal assaults on their professionalism.

Dr. William H. Welch declared as president of the AMA in 1910: "Organized effort is a distinguishing mark of modern civilization...We are justified in the confidence that, with the united support and loyalty of the profession, this Association--broadly representative and standing for the best ideals of medical science and art and for professional and civic righteousness -- will contribute a beneficial share to the working out of our national destiny."

For physicians, this destiny is more at stake now than ever before. And for physicians--new or established, young or old--the need for organized national effort is greater, too.

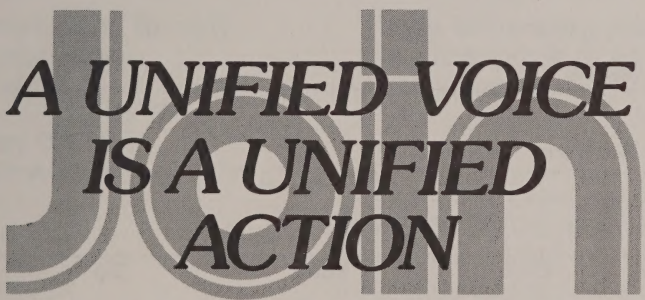
Let the word be spread that the AMA is a mountain -- and not a mist. □

MEMBERSHIP COMMITTEE

The committee on Membership met on Thursday, January 11, 1979 in the offices of the H.D.M.S. Prsent were Drs. Navazio, Chairman, Hough, Flahive and Botnick. Also present were Mrs. Richard Miller, President of the Auxiliary, Mrs. John Medrek, President-Elect of the Auxiliary and Vivian Purdy. The purpose of the meeting was to discuss increasing membership in the Hampden District Medical Society, as well as the state society and the national association.

Several methods of recruiting were considered. One is to approach the Senior member of each group practice and ask that new members of their group be encouraged to join and names be given to the medical society office. Another method is to write the President of each hospital asking for names of new physicians as they obtain staff privileges. Any physician member who knows of a new doctor or an established one who does not belong should talk with him and ask the medical society to send him an application blank with a welcoming leter. The Auxiliary to the medical society has a "Welcome Wagon" system that they employ. Wives of new physicians in the area are welcomed by either the president, the president-elect or a designated member in an area and materials about the area are given to the person and they are welcomed as members of the Auxiliary.

A concenterated drive for membership will start at once. As the Massachusetts Medical Society states in their brochure "The need for a unified voice and action by the medical profession is essential".



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WHAT DIRECTION NOW?

....''Who are we? What is our image in the community? We know where we've been, but where do we go?'' These are some of the questions the auxiliary is asking itself these days under the direction of our president Polly Miller. A questionnaire was sent to the membership asking individual opinions concerning these issues. Major board decisions are pending and will be made on the conclusions of this membership input. This will, hopefully, result in an update of our purposes. □

HELEN GALLIVAN
Auxiliary Representative
to the Hippocrat

Application for Membership
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Last First

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Interests and Hobbies _____

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WELCOME

Our WELCOME WAGON KIT has received special recognition in "Facets", the magazine published by the American Medical Auxiliary, Inc. The kit contains museum guides, local magazines, sightseeing brochures, a restaurant guide, maps, a listing of cultural events and a welcoming letter from our auxiliary president Polly Miller. An auxilian meets prospective new members when the kit is personally delivered. If you know of a doctor's wife who is new to Hampden County, please contact our membership chairman, Jean Medrek (525-6052). □

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Mrs. Robert O'Brien
7 Roosevelt Avenue
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Marion White [Mrs. Robert]
130 Steiger Drive
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TERMINATION OF THE PHYSICIAN-PATIENT RELATIONSHIP

There are many reasons why you, as a physician, might wish to end a relationship with a patient. Contrary to what some physicians believe, it is possible to terminate the physician-patient relationship. Here are two cases with commentary that illustrate some of the points you should keep in mind.

CASE ONE: Dr. Bill, a specialist in urology, surgically removed a kidney stone from Mrs. P. A drain was placed in the area of the incision. Ten days after surgery, the exposed portion of the drain tube was clipped off at the skin surface by a resident. Five days later, Dr. Bill discharged Mrs. P. from the hospital and considered his relationship with her to be terminated. For the next six weeks, Mrs. P. experienced pain in her side, persistent draining from the incision, fever, and chills. Dr. Bill did not see her again. In the subsequent malpractice suit, Dr. Bill was held liable for ''abandoning'' his patient.

CASE TWO: Dr. Dave, a general surgeon, surgically repaired Mr. C.'s inguinal hernia. For a period of two years, Mr. C. continued to experience low abdominal and genital discomfort. Over this period, he consulted several physicians, both on Dr. Dave's referral and otherwise. Finally, two years after the initial surgery, Dr. Dave informed Mr. C. that, in his opinion, no medical doctor could help him further and after a specific date, he (Dr. Dave) would no longer treat Mr. C. Subsequently, Mr. C. underwent further surgery which alleviated his pain. He later brought suit against Dr. Dave for ''abandoning'' him. The court exonerated Dr. Dave of this charge.

The two cases, substantially based on actual court decisions, are quite similar, yet opposite results were reached. Precisely what is your obligation to patients, and how may you properly terminate the physician-patient relationship?

After the physician-patient relationship has begun, you as a physician are legally (and ethically) obliged to attend the case as long as it requires attention, unless you and the patient have specifically agreed otherwise or the patient has dismissed you as his physician.

This does not mean, however, that you remain tied to a patient forever. A physician does have a right to withdraw from a case. But, if you wish to discontinue your services before the need for them is at an end, you must first give due notice to the patient and afford the patient ample opportunity to secure other medical attention of his own choice. This is precisely whtat Dr. Dave did in his second case presented above.

If you simply cease to provide services, however, without giving the patient such notice and opportunity to procure the services of another physician, you are likely to be held liable for ''abandonment.'' This is the error made by Dr. Bill, who assumed that discharge from the case.

If you wish to withdraw from a case, you will want to be certain that you have followed the proper procedure. It is advisable to write a letter to the patient explaining the situation, wheter or not you have done so verbally. Preferably, the letter would be sent **certified mail**, return

receipt requested (not registered--the Postal Service advises that registered mail is for items of specific monetary value, such as bonds, stocks, airline tickets, etc.) All correspondence with patients, including letters of this sort, should be duplicated, with a copy retained in the patient's chart. While certified letters and retained copies are not required by law (verbal notice is all that is necessary) such precautions can inexpensively prevent anguish if questions are later raised about the termination of the relationship.

A sample form of a terminationletter is reproduced here. This form is only a suggestion and may be varied according to your own style and the advice of your local attorney. In this sample, the given reason for termination is failure to follow medical advice. A number of other acceptable reasons may be advanced to justify termination. It's important, however, that you don't assume that the occurrence of any event (such as leaving the hospital, missing an appointment, filing legal action) automatically terminates the relationship. Follow the steps outlined above, if there is any question that the patient might continue to consider you "his doctor."

One final point should be addressed. What constitutes adequate time for the patient to seek other medical attention? No definitive answer is possible because much depends on the circumstances of each case. Factors to be taken into consideration are the condition of the patient, the size of the community and the availability of other physicians. Perhaps the patient will never seek additional care. The physician is nevertheless obligated to continue to be available to that patient and to help him find other medical attention if he so desires.

To summarize, you needn't feel bound to a patient whom you do not wish to serve. Such a forced relationship can only be acerbic and not beneficial to either party. You do have an obligation to those with whom you have a relationship, however. This obligation extends at least to clearly notifying the patient that the relationship is at an end.

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FORM A-1
LETTER OF WITHDRAWAL FROM CASE

Dear Mr._____:

I find it necessary to inform you that I am withdrawing from further professional attendance upon you for the reason that you have persisted in refusing to follow my medical advice and treatment. Since your condition requires medical attention, I suggest that you place yourself under the care of another physician without delay. If you so desire, I shall be available to attend you for a reasonable time after you have received this letter, but in no event for more than five days.

This should give you ample time to select a physician of your choice from the many competent practitioners in this city. With your approval, I will make available to this physician your case history and information regarding the diagnosis and treatment which you have received from me.

Very truly yours,

_____, M.D.

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In Memoriam

WILLIAM N. WHITTLESEY, M.D.

William N. Whittlesey, M.D. of Longmeadow died in the Holyoke Hospital on October 14, 1978. Born in Brooklyn, N.Y. he received his primary education there, his pre-medical at Middlebury College in Vermont and his medical education at the Long Island College of Medicine. His internship and residency were accomplished in Brooklyn Hospital and St. Vincent's Hospital in New York.

Dr. Whittlesey was certified by the American Board of Pathology and was on the staff of Holyoke Hospital.

He was a member of the American Medical Association the Massachusetts Medical Society and the Hampden District Medical Society.

H.D.M.S. extends deepest sympathy to his family and many friends. □

In Memoriam

HOWARD PEARSON KENNEDY 1901-1978

Dr. Kennedy graduated from the secondary schools of Worcester at sixteen but several years ensued before he entered Howard University earning a B.A. in 1924. He taught school two years, then entered and graduated from Meharry Medical School in 1930. Upon Completion of his internship at Kansas City General #2 he came to Springfield in 1931 to practice medicine.

He started as a physician on the Courtesy Staff of Springfield Hospital and received his first hospital appointment May 1944, and subsquently became Physician in Chief October 1955. On January 28, 1975 he received recognition for thirty years service from Springfield Hospital.

An interest in Cardiology motivated specialized study at Mt. Sinai and Montefiore Hospitals in New York City and Peter Bent Brigham Hospital in Boston. He authored an article in the New England Journal of Medicine 1947, became a Diplomate of the American Board of Internal Medicine in 1950, the Clinical Director of Professional Services at Springfield Municipal Hospital 1961-1965, and a member and Fellow in many local and national professional societies including American College of Physicians.

Howard explored new areas and pursued interests other than medicine. He received a certificate of recognition by the Urban League in 1949 for his community efforts on behalf of equal opportunities for jobs and housing for minorities during a period when this was considered reactionary. As a "ham" radio operator he indulged in trans-continental conversations with operators who spoke English and pursued with vigor wood finishing. He was an active member of Christ Church Cathedral.

At the time of his death December 31, 1978 he was college physician at Western New England College in Springfield.

He is survived by his wife, the former Marion Hill, two daughters, Mrs. Constance Young of California, Mrs. Adrienne Powell of Maryland and three grandchildren. □

ALONZO D. SHEFFIELD

Howard P. Kennedy, M.D. died on December 31, 1978 at Baystate Medical Center, Springfield Unit.

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In Memoriam

M. GENE BLACK, M.D.

On Christmas Eve, last the entire greater Holyoke community was saddened by the news of the death of one of its most distinguished and dedicated physicians. "No other physician has had such a positive impact on the quality of medical care in this community in the past thirty years." Those of us who have worked with Gene Black admired her and loved her will say "amen" to the preceding quotation.

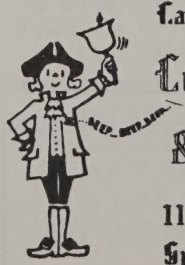
"Dr. M. Gene Black, of 51 East St., South Hadley, former chief of the anesthesiology department at Holyoke Hospital and the 31st recipient of the William G. Dwight Award for distinguished public service, died Sunday, at Holyoke Hospital."

There is a particularly beautiful little park in Holyoke with a majestic view of the upper Pioneer Valley which today would have been a redundant and unattractive filling station, but for the quiet persuasive efforts of Dr. Black.

She was a member of the College of Chest Physicians, an organizer of the League of Women Voters and a director and medical confidant of the Loomis House, a house for the elderly in Holyoke. Her constant solicitude for the well being of her elderly patients and friends was characteristic of her and a life-long habit.

Dr. Black's funeral services were held in All Saints Episcopal Church, in South Hadley, Monday. Her eulogy was given by her long time personal friend the Reverand Clarke of Amherst. In a simple yet moving way and still the more convincing because of its simplicity he said, "Gene is alright? She's with God now." Those of us fortunate enough to have been associated with this dedicated, caring and talented physician can only agree. □

ROBERT D. O'MALLEY



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FASCINATING CURES EVOKED BY FAITH-HEALING

Recently a startling medical-religious cure came to my attention in one of the families whose children I attend. The father, R.L., has had adult-onset diabetes requiring amounts of daily insulin as high as 60 units who has now been off all insulin for the past ten months and maintains a normal blood sugar. This dramatic situation followed charismatic services by Father R. D'Orio, presently at St. John's Church, Worcester, Massachusetts. Dr. J.B., the physician of R.L., feels that perhaps this came about as a result of a change in jobs and resultant possible increase in exercise, but the patient is strong in his conviction that this change came about dramatically as the result of a particular faith-healing service in February, 1978.

Also, one of the local newspapers this fall carried an article on L.P., who had been confined to a wheelchair for twenty years, but during charismatic services by Father D'Orio on August 27, 1978 he was told he would be cured and was told to stand. He states it all happened so fast that for a moment he didn't realize that he had stood up. Not only that, but he walked down the aisle to the sanctuary before he had to sit down in emotional bewilderment. He has been walking ever since and according to his physician, Dr. M.T., his leg muscles have essentially tripled in size. However, perhaps the most amazing thing is the complete disappearance of the pain of his back, neck and arms for which he had been taking Percodan, Seconal and occasional injections of Demerol. His problem started about 20 years ago with a low back problem for which he had two operative procedures. Following one of the procedures, he became paralyzed. Rather intractable pain of his back, arms and neck has been a major problem the past few years. A local neuro-surgeon implanted a dorsal column stimulator, but this did not ease his pain. He states that now he takes no Percodan and only occasional asprin.

I was also referred to Dr. M.T. regarding another instance of dramatic reversal of symptoms and mucosal finding in R.P., a 35 year old man who had had ulcerative colitis for about seven years. He had had marked mucousy diarrhea, often with blood, and was on a very restricted diet plus medication. Endoscopy revealed the friable mucosa and x-rays revealed the stove-pipe rigidity of the bowel wall. On October 5, 1978, he was prayed over by Father D'Orio and told he was cured. After the service he stopped at a restaurant and ate hamburg and french fries, which before would have given him tremendous mucousy diarrhea. He had absolutely no difficulty and in fact since has been on a completely regular diet, has one normal bowel movement a day and requires no medication. He has been scoped since with the startling finding that his mucosa is now normal - although the x-rays continue to show bowel wall rigidity.

These are the instances of debilitating conditions which have undergone dramatic reversal following charismatic services, of which I am presently aware. They are presented for your interest, consideration, and comments. If you are aware of cases in this category, I would appreciate hearing from you. □

CARL JANOVSKY, M.D.

CURRENT CONCEPTS IN THE MANAGEMENT OF ADVANCED MALIGNANCIES

It is to be held March 21, 1979, at the Springfield Marriott Hotel. The program will consist of speakers:

Dr. Richard Wilson, Professor of Surgery,
Harvard Medical School
Chief, Surgical Oncology, Peter Bent Brigham Hospital, Boston, Ma.
ADVANCED BREAST MALIGNANCIES;

Dr. Harry Goldsmith, Professor of Surgery,
Dartmouth Medical School
ADVANCED MALIGNANCIES OF THE COLON;

Dr. Robert K. Rhamy, Professor and Chairman,
Department of Urology, Vanderbilt University
School of Medicine, Nashville, Tenn.
ADVANCED PROSTATIC CARCINOMA;

Dr. William Collins, Professor and Chairman,
Department of Neurosurgery, Yale Medical School
Yale-New Haven Hospital
CURRENT CONCEPTS IN THE MANAGEMENT OF PAIN IN METASTATIC CARCINOMA;

Dr. Benjamin Ianzito, Chairman
Department of Psychiatry
Baystate Medical Center
THE PSYCHOLOGICAL PROBLEMS IN MANAGEMENT OF THE TERMINALLY ILL PATIENT

Seminar information can be obtained from:

Dr. Gregory A. Slachta
120 Maple Street
Springfield, Mass.
Tel: 785-5321

and

The American Cancer Society
57 Pearl Street
Springfield, Mass.
Tel: 785-1545

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NEWS

An AMA survey of state medical disciplinary boards has found that disciplinary actions against physians increased six-fold between 1971 and 1977. In 1971 there were 119 actions brought against physians. In 1977 there were 685. Much of the increase can be attributed to the rising number of states providing immunity from civil liability for persons making reports to state disciplinary boards, an AMA spokesman said.

The AMA Education and Research Foundation continues to provide financial support to needy students and physicians in training. During the first nine months of this year, the AMA-ERF guaranteed more than $4 million in new loans.

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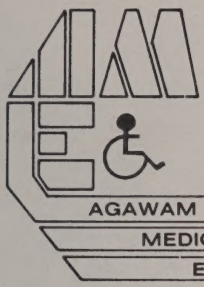

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